need for mass dissemination and cost and logistical limitations associated with face-to-face training. Because CBT treatment researchers are well placed to examine the effectiveness of current practices in disaster mental health and to adapt what has been learned about brief intervention methods in other domains of care to enhance the impact of brief postcatastrophe services, and because many cognitive-behavioral treatments are compatible with an "educational" model of service delivery, CBT methods can be expected to figure prominently in developments in mass violence and disaster response.

References

Bryant, R. A., & Harvey, A. G. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment.* Washington, DC: American Psychological Association.

Bryant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry, 156,* 1780-1786.

Foa, E. B., Hearst-Ikeda, D., & Perry, K. J. (1995). Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology, 63,* 948-955.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford Press.

Freedy, J. R., Shaw, D., Jarrell, M., & Masters, C. (1992). Towards an understanding of the psychological impact of natural disasters: An application of the conservation resources stress model. *Journal of Traumatic Stress, 5,* 441-454.

Kaniasty, K., & Norris, F. (1993). A test of the support deterioration model in the context of natural disaster. *Journal of Personality and Social Psychology, 64,* 395-408.

Therapist Reactions in the Context of Collective Trauma

Sonja V. Batten and Susan M. Orsillo, *National Center for PTSD, VA Boston Healthcare System,* and *Boston University School of Medicine*

The events of September 11, 2001, and the days that followed placed psychotherapists in the United States in a situation that most had never confronted. How were we best to continue with our day-to-day work in the face of such dramatic and tragic events? Although aware that many other areas of the world experience large-scale violence on a somewhat frequent basis, how many of us had stopped to consider what it would be like to try to conduct therapy in the midst of ongoing violence and uncertainty? For many Americans, going to work in the days after September 11 provided some measure of distraction or separation from the seemingly endless news reports and speculations about what would come next. However, for those of us who provide clinical services, our work was often not a place of escape as we discussed the events repeatedly with our clients. Likewise, as clinical supervisors, we needed to check in with our supervisees about how they were doing, even when we were tired or overwhelmed.

No longer immune to acts of terrorism on our own soil, therapists in the U.S. have struggled in their own ways to come to terms with their reactions to the recent events and how those reactions impact on the therapeutic process. Although previously the purview of more dynamic, humanistic, or interpersonal therapists, behavior therapists have also come to recognize the importance of attending to in-session therapist reactions in order to provide effective treatment (e.g., Kohlenberg & Tsai, 1991). If unexamined, the ways that therapists respond to their own private events can not only create difficulties for themselves, but can also potentially impede the progress of their clients.

In this article, we will attempt to describe some of the common reactions that we observed in behavioral and cognitive-behavioral therapists in the days immediately after September 11. We expressly focus on the experiences of therapists who were not in the New York or Washington, D.C., areas and who did not lose a loved one in the terrorist attacks. Other articles in this series focus on the experience of therapists who were closer to the acute results of the terrorism. Our goal was to describe the experiences of the broader population of therapists across the United States. We then briefly review literatures from several different areas in an attempt to provide some preliminary empirical support (rather than an exhaustive literature review) in validation of the responses that the therapists we spoke to described. We conclude with some suggestions for therapists struggling with their own reactions and with those of their supervisees, and we make a few recommendations for future research.

Observations

In the days and weeks following September 11, we spoke with many behavioral and cognitive-behavioral therapists not directly impacted by the attacks who were surprised by the range and intensity of their own in-session emotional reactions. One of the most common themes was that of being exhausted and shocked by the events and their ramifications. Some therapists reported feeling guilty in session because they did not feel as effective as usual, while others reported that they were so tired of hearing about the situation that they might have subtly and unintentionally discouraged their clients from talking about the events to meet their own needs. Other commonly reported responses involved therapists having similar emotional reactions to their clients. For example, some therapists noted that they were already feeling sad and overwhelmed by all that was going on, such that it was very painful to sit with clients who were feeling similarly. Other therapists reported that their own intense anger toward the terrorists may have interfered with their effectiveness in working with clients' anger toward the terrorists. Some therapists also discussed the difficulty in balancing their concerns for the well-being and safety of themselves and their family members, while also attempting to remain available for their clients. Taken together, these reactions reflect the simple, but sometimes forgotten, truth that therapists are human beings too and thus are susceptible to the direct effects of stressful and traumatic events. However, it is also important to note that not all therapist emotional reactions were experienced as obstacles to effective therapy. We also spoke with a number of therapists who reported that the level of emotional intensity that they experienced in the wake of the terrorism actually allowed them to be in better contact with their clients' emotions and helped them to respond more empathically and effectively in session.

While many of these reactions may have been anticipated, other responses that we observed were experienced by therapists as more surprising and complicated. Specifically, many therapists were surprised by clients who appeared to have

no emotional reaction at all to the September 11 attacks. Some therapists reported feeling confused or even irritated by such (lack of) client reactions. While the therapist should never dictate what emotional reaction the client should be having in a particular situation, our experience was that this lack of response was often symptomatic of a high level of avoidance characteristic of the individual client. When conceptualized this way, our own in-session responses led us to probe clients for further reactions in order to work effectively with this avoidance. For example, one of our combat veteran clients surprisingly appeared to be having no response to the terrorist attacks; however, with prompting, the client was able to describe how he had been trying not to think about the events because they reminded him of a rescue-and-recovery mission he had been on in Vietnam.

In other cases, we saw nonreaction by clients to the terrorist attacks as reflecting a pervasive, generalized (rather than trauma-specific) style of avoidance. For instance, a female client who was seen on the day of the attacks spent the entire session complaining about her interactions with coworkers and seemed indifferent to the loss of lives and threat of ongoing violence associated with the attacks. Over several sessions, the therapist was able to eventually conceptualize this avoidance as characteristic of this client's basic disconnection with any sort of meaningful and fulfilling life. The in-session reaction that the therapist had to this client prompted her to encourage her client to more closely examine what she wanted out of her life. This exercise led the client to reveal her strong fear and avoidance of the inevitable pain that she felt when she allowed herself to care about herself and others.

In the days following September 11, therapists also described a blurring of boundaries—it became more difficult than usual to determine whether it was appropriate for the therapist to disclose his or her own personal reactions to and methods of coping with the situation. On the one hand, such disclosure can model effective coping strategies for clients. However, many therapists felt that it was difficult to communicate these efforts while they were still experiencing their own strong reactions.

Relevant Literature

The literature can guide the struggling behavior therapist in negotiating the impact of a large-scale trauma, both in terms of the therapists' own functioning and the ability to provide effective services to their clients. A full review of the literature is beyond the scope of the current article, but we will cite a few examples to offer a framework for understanding therapists' reactions to the September 11 events.

There is a small but potentially useful literature on the experience of therapists who have recently come into contact with a significant stressor in their own lives. Not surprisingly, few of these writings come from a behavioral framework (although we believe that these issues can be conceptualized and studied from a behavioral perspective), and most are based on anecdotal accounts. For example, Morrison (1996) explores the impact that the death of his wife from cancer had on his therapeutic practice, describing how his "forced" disclosure of this event to his clients changed his work with each of them. Expanding on this issue, Bula (2000) provides excerpts from interviews with several therapists who recently experienced a traumatic event, demonstrating how they handled their own stress in the context of their psychotherapeutic practice. Importantly, these therapists shared not only how their pain and stress impacted their therapeutic practices in a negative way, but also how their own traumatic experiences allowed them to be more empathic and able to listen to their clients.

Furthermore, some writers have discussed the impact that a traumatic event in the client's life that is similar to a traumatic event in the therapist's past can have on the therapist and the therapeutic process. For example, a therapist with her own sexual abuse history who treats sexually abused clients may have heightened or blunted responses to in-session client material around the abuse (Pearlman & Saakvitne, 1995). In such cases, it has been recommended that the therapist be especially watchful for his or her own reactions in session and seek appropriate supervision or consultation to ensure that the therapist's personal reactions are handled appropriately (Follette & Batten, 2000).

Another literature that potentially bears on the current issue is that on secondary or vicarious traumatization. This literature identifies a process in which the therapist's private events, and thus the therapeutic relationship, are impacted (often negatively) by empathic engagement with clients' trauma material (Cudmore & Judd, 2001; Pearlman & Saakvitne, 1995; see, in this issue, Palm, Smith, & Follette, 2002, for further detail on vicarious trauma and suggested self-care strategies). And while therapists closest to the terrorist attacks were certainly dealing with clients most intensely traumatized by these recent events (see both Walser, 2002, and Lubetkin, 2002, this issue), therapists across the country were processing and reprocessing their clients' reactions to the assaults on New York, Washington, DC, and Pennsylvania. Thus, the theory of vicarious traumatization would suggest that many therapists might have experienced difficulties simply as a result of suddenly working with so many clients who felt that they were under conditions of significant stress or trauma. However, not all studies have found negative effects on therapists from working with traumatized clients. For example, in one of the few studies comparing therapists at high and low risk for vicarious traumatization due to their caseload of trauma survivors, trauma therapists did not show increased psychopathology or distorted cognitive schemata when compared to nontrauma therapists (van Minnen & Keijsers, 2000). Further, although helpful, the theory of secondary or vicarious traumatization does not seem to fully capture the experience of a therapist struggling with his or her own issues, in addition to the client's issues, following a large-scale stressful or traumatic event.

Different from a circumscribed stressful event in the therapist's life (such as a single traumatic event) or a current event in the client's life that brings up painful emotions in the therapist, September 11 brought therapists and clients face to face with a significant current stressor that was of high intensity for both individuals in the therapy relationship. As the U.S. has been sheltered from such experiences in modern times, we turned to the international literature for theory and data with which to understand the experiences of U.S. therapists in the wake of the recent terrorism and how these reactions might impact the work of therapy.

One nation that has unfortunately seen much violence over the past 50 years is Israel. Psychotherapists within Israeli culture have been forced to pay attention to the impact that the shared reality of violence can have on the normal therapeutic practice (Kretsch, Benyakar, Baruch, & Roth, 1997). For example, Tauber (2001) has written about the experience of doing psychotherapy in Israel during the sudden eruptions of violence surrounding the Rosh Hashanah holiday of the year 2000. In her interviews with a number of psychotherapists who provide therapy to Holocaust survivors and second-generation clients, she identified the same challenges to therapists that we personally saw in our own clinical practice here in the U.S. after September 11: coping with fears about personal physical safety and well-being while still remaining available to help clients with their responses and needs. As we noticed in the U.S., the therapists in Tauber's study reported a wide range of responses to the

acts of violence, ranging from becoming psychologically less available to their clients to becoming more understanding and sensitive to clients' experiences.

Based on work in a war zone in Bosnia, Ostodic (1999) describes a process in which the professionals working in a war region suffer both primary and secondary (or vicarious) trauma, as they are both members of a traumatized community as well as mental health professionals to traumatized individuals. This difficulty is probably best matched by the situations of psychotherapists in the New York and Washington, DC, areas. For example, one therapist in New York City shared with us her difficulty in going to work, having to smell the smoke from the World Trade Center, being confronted with evidence of widespread death in the form of MISSING posters, and then having to shore herself up for conducting a day of psychotherapy. Ostodic also describes the additional responsibility that many mental health professionals feel, approached by friends, family members, and coworkers who want to discuss their own reactions, seemingly unaware of the fact that we may be struggling with the same events.

A final example is that of Chile, in which psychotherapists were working under conditions of state terrorism due to the dictatorship's widespread human rights violations. Agger and Jensen (1994) interviewed 40 psychotherapists in Chile and found that many of the therapists and physicians had themselves been tortured or exiled; thus, this sample may be somewhat extreme for comparison with the general therapist population in the U.S. However, the study brings up interesting issues related to the beneficial and potentially deleterious "bond of commitment" that was developed within the therapeutic relationship as a result of similar experiences between the therapist and client.

Summary and Implications

The anecdotal reports we have collected from behavioral and cognitive-behavioral therapists, and the related literatures we have touched upon, suggest that therapists and clients can both struggle with their reactions to a shared threat in a way that can impact the therapeutic process. This impact can have positive and negative effects that seem to be related to the therapists' appraisal of and coping orientation to their own reactions (Kohlenberg & Tsai, 1991). A number of thoughts and suggestions that arise from our observation of this process may deserve empirical study and could be considered by currently practicing therapists. One striking, but not surprising, observation is that therapists' personal reactions to significant stressors and the impact on the therapeutic relationship have largely been ignored by behavior therapy (with the most notable exception being the work by Kohlenberg and Tsai) and mostly explored by psychodynamic and humanistic/existential writers and trauma therapists. We are concerned that the oversight and marginalization of this process may negatively affect behavior therapists, particularly students and trainees, who privately struggle with their own reactions to terrorism while clients and supervisors demand increases in service and overextensions in work.

We contend that such reactions are part of the normal human response to danger and loss and that it is the suppression and avoidance of these reactions, not simply the experience of the reactions, that can impede the therapeutic process. For example, a therapist who suppresses his or her own feelings of helplessness or powerlessness might instead attempt to intervene in a way that is greater than what is therapeutically indicated. Similarly, a therapist who keeps strong reactions from a supervisor may accept work that is beyond his or her own current capacity. Furthermore, attempts to avoid one's reactions within a therapy session may result in the therapist subtly moving the client away from important material and becoming distracted and disconnected from the client. While noticing one's own reactions and giving up the struggle to control them can be painful, we maintain that this approach actually increases our empathy and effectiveness with our clients. This stance follows from our theoretical orientation and clinical experience, but is in need of further empirical validation.

While our position to this point has been that therapists, as human beings, obviously bring their own reactions to the events of September 11 to the therapeutic setting, and that these reactions are normal and can actually enhance the work of therapy, we absolutely acknowledge that there are cases in which a therapist's own personal reactions could be so intense that they may interfere negatively with the process of therapy. The ethical guidelines for psychologists state clearly that psychologists should not engage in therapy or any other professional activity when their own personal problems may interfere with their effectiveness (American Psychological Association, 1992). Although the reactions of most therapists can be dealt with in a manner that does not interfere with the work of therapy, there may also be occasions in which the most appropriate response to intense emotional reactions may be to not continue with treatment. We suggest that all therapists seek consultation or supervision for their practice, particularly after large-scale, collective traumatic experiences such as those that occurred on September 11. We believe that the struggle with one's own reactions and the impact of that struggle on therapeutic effectiveness must be discussed with empathic supervisors, supervisees, and colleagues. In fact, in the wake of the Oklahoma City bombing, those therapists in the area who reported receiving the most empathic support from others were those who had the lowest levels of secondary traumatization and psychological distress (Landry, Jenkins, & Morris, 1999). In these difficult times, we are reminded that we are no less vulnerable or prone to strong reactions than our clients. In fact, we believe that it is our awareness and acceptance of our emotional and cognitive reactions that will allow us to model effective coping for our clients while strengthening the human aspect of the therapeutic relationship.

References

Agger, I., & Jensen, S. B. (1994). Determinant factors for countertransference reactions under state terrorism. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. 263-287). New York: Guilford Press.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597-1611.

Bula, J. F. (2000). Differential use of self by therapists following their own trauma experiences. In M. Baldwin (Ed.), *The use of self in therapy* (2nd ed., pp. 213-241). Binghamton, NY: Haworth Press.

Cudmore, L., & Judd, D. (2001). Traumatic loss and the couple. In C. Clulow (Ed.), *Adult attachment and couple psychotherapy: The "secure base" in practice and research* (pp. 152-170). Philadelphia: Brunner-Routledge.

Follette, V. M., & Batten, S. V. (2000). The role of emotion in psychotherapy supervision: A contextual behavioral analysis. *Cognitive and Behavioral Practice,* 7, 306-312.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional Analytic Psychotherapy: Creating intense and curative therapeutic relationships.* New York: Plenum.

Kretsch, R., Benyakar, M., Baruch, E., & Roth, M. (1997). A shared reality of therapists and survivors in a national crisis as illustrated by the gulf war. *Psychotherapy, 34,* 28-33.

Landry, L. P., Jenkins, S. R., & Morris, S. (November, 1999). *Secondary traumatic stress disorder in the therapists from the Oklahoma City bombing.* Paper presented at the annu-

al convention of the International Society for Traumatic Stress Studies, Miami, FL.

Lubetkin, B. (2002). A behavior therapist's response to the World Trade Center disaster: A personal narrative. *the Behavior Therapist, 25,* 30-32.

Morrison, A. P. (1996). Trauma and disruption in the life of the analyst: Enforced disclosure and disequilibrium in "the analytic instrument." In B. Gerson (Ed.), *The therapist as a person: Life crises, life choices, life experiences, and their effects on treatment* (pp. 41-54). Hillsdale, NJ: Analytic Press.

Ostodic, E. (1999). Some pitfalls for effective caregiving in a war region. *Women & Therapy, 22,* 161-165.

Palm, K. M., Smith, A. A., & Follette, V. M. (2002). Trauma therapy and therapist self-care. *the Behavior Therapist, 25,* 40-42.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Tauber, Y. (2001). *High Holidays 2000 and aftermath: The experience of doing psychotherapy with Holocaust survivors and the second generation in Israel during the sudden eruptions of violence.* Unpublished manuscript.

Van Minnen, A., & Keijers, G. P. J. (2000). A controlled study into the (cognitive) effects of exposure treatment on trauma therapists. *Journal of Behavior Therapy and Experimental Psychiatry, 31,* 189-200.

Walser, R. D. (2002). Disaster response: Professional and personal journeys at the Pentagon. *the Behavior Therapist, 25,* 27-28, 30.

Trauma Therapy and Therapist Self-Care

Kathleen M. Palm, Alethea A. Smith, and Victoria M. Follette, *University of Nevada, Reno*

In the wake of the attacks of September 11 there has been an increased demand on mental health services both across the nation and specifically in New York, Washington, DC, and the surrounding areas. Experience from the Oklahoma City bombing and other recent disasters, however, suggests that the brunt of the impact on mental health facilities and therapists may be yet to come (Sealey, 2001). It is expected that as many as 1.5 million New Yorkers could need mental health services in the next few months and years as a direct result of the events of September 11 (Sealey). Furthermore, in a recent survey of stress reactions after the terrorist attacks, researchers found that a large percentage of participants located geographically far away from the sites of the attacks reported substantial stress (Schuster et al., 2001). Therefore, regardless of geographic location, therapists across the country need to be prepared to help people with trauma-related symptoms. While the focus of attention has been on preparing to meet that need and provide quality services to the traumatized, the risks to caregivers, including psychotherapists, are significant and should also be addressed.

Both theoretical and empirical literatures have suggested that work with trauma survivors can affect therapists negatively. Trauma experts have found strong correlations between doing therapy with trauma survivors and therapist symptoms of posttraumatic stress disorder (PTSD; Schauben & Frazier, 1995), negative coping strategies (Follette, Polusny, & Milbeck, 1994), and strain on intimate relationships (McCann & Pearlman, 1990). This phenomenon has been labeled in a variety of ways, for example, vicarious traumatization (Pearlman & Saakvitne, 1995a), secondary traumatization (Figley, 1995), and burnout (Freudenberger, 1980). The underlying concern of all of these concepts, however, is the impact that exposure to traumatic material has on professionals. Such exposure to traumatic material may include actually experiencing the trauma, hearing about the events from clients, or watching the events occur on television.

Empirical research, although somewhat limited, does suggest that a therapist's adaptation to traumatic material will depend on the characteristics of both the situation and the therapist. Characteristics of the situation include exposure to graphic details of the event and consecutive sessions with trauma survivors (Pearlman & Saakvitne, 1995a). This may be important to remember in the context of September 11 as many clients have been affected directly by this one event. Not only will therapists be exposed to a heavier trauma caseload, but they may also be exposed to consecutive sessions dealing with the same overall trauma content.

Therapists' level of personal exposure and loss is also related to the therapists' stress levels. Follette et al. (1994) found that self-reports of current personal stress were more predictive of therapists' traumatic symptoms than history of abuse. There are a number of stressors related to the events of September 11 that are likely to be affecting therapists' personal lives, including the loss of friends or family, the loss of economic security, and fear for personal safety. These stressors may increase therapists' vulnerability to psychological and emotional distress, which may impact their professional work.

While data linking trauma exposure to professional performance are limited, it is reasonable to predict that there could be some negative impact. In the most basic sense, high levels of exposure to traumatic material can deplete the therapist of physical and emotional energy, thus lessening the resources he or she brings to each therapy relationship (Pearlman & Saakvitne, 1995a). This may strain the therapist's ability to remain empathetic with clients over time or result in the therapist taking the part of the rescuer, violating therapeutic boundaries, or exhibiting excessive affect in identifying with the victims' rage and grief (Herman, 1992; Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1989; Wilson & Lindy, 1994). Disruptions of this type can negatively influence the therapeutic relationship, particularly problematic in work where an intense therapeutic relationship is an important component of treatment (Kohlenberg & Tsai, 1991).

Given the potential negative effects that exposure to traumatic material can have on therapists, it is more important than ever for therapists to be aware of their reactions and take steps to promote their own well-being. Although the research in this area is limited, there is a general consensus among trauma experts that focusing on therapists' trauma responses exclusively misses the greater scope of the problem (Follette et al., 1994; Kirmayer, 1996; Pearlman & Saakvitne, 1995a). Responding effectively to the needs of both therapists and clients requires consideration of both the individual and the larger context.

Individual Considerations

In addition to those accounts reported by clients, trauma workers will be assailed by their own personal responses to the terrorist attacks. Although the exposure to traumatic material can be overwhelming, therapists can take action in order to provide the best care for both their clients and themselves. First and foremost, therapists should take time to attend to their personal needs. Trauma workers should engage in more behaviors that promote physical health (Clay, 2001), such as sleep, exercise, and balanced nutrition. Other important considerations for therapists doing interpersonally demanding